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New Jersey Culturally and Linguistically Appropriate Services Standards for HIV/AIDS Services

Implementation Guide

NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES
Division of AIDS Prevention and Control

CCOE CENTER FOR CONTINUING & OUTREACH EDUCATION UMDNJ
Division of AIDS Education

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New Jersey Culturally and Linguistically Appropriate Services Standards For HIV/AIDS Service Providers

INTRODUCTION

The population of New Jersey is increasingly diverse, perhaps even more so than the well-documented diversity of the nation as a whole. Increases in minority and foreign-born populations create a richness and depth to the statewide "neighborhood." However, diversity can also create barriers and obstacles to the ability of individuals to achieve full participation in the benefits of society, especially those related to health and human services, education, and medical treatment services. Each individual possesses a specific and distinctive mix of cultural, ethnic, religious, sexual orientation, substance abuse, or linguistic history. Unfortunately, institutions and organizations often lack the capacity to respond to the unique and complex needs of diverse populations, creating frustration and diminishing the ability to deliver essential services. In the case of HIV and AIDS, the stigma attached to this disease has exacerbated the marginalization of the populations impacted by this epidemic, particularly women, people of color, Latino populations, injecting drug users, men who have sex with men, transgendered individuals, individuals who exchange sex for resources, and people living with HIV or AIDS.

The importance of striving for cultural competence and linguistic appropriateness is universally acknowledged. However, a wide gap remains between good intentions and the development of skills, abilities, policies, and operating procedures that are necessary to achieve this goal in services delivered to minority and marginalized populations. While there are several excellent theoretical models for implementing cultural competency, many lack measurable cultural and linguistic standards to guide the implementation process. This is especially true relative to HIV services.

In 2001, the US Department of Heath and Human Services' Office of Minority Health published a set of proposed national standards of Culturally and Linguistically Appropriate Services (CLAS) for health care services. The driving force for this effort was a commitment to eliminate racial and ethnic disparities in health care, and to assure equal access to services for individuals with limited English proficiency. In this document cultural and linguistic competence is defined as "a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that *enables effective work in cross-cultural situations."*

NEW JERSEY EXPERIENCE

In 2001, the New Jersey Department of Health and Senior Services (NJDHSS), Division of AIDS Prevention and Control (DOAPC) initiated a process designed to advance the delivery of culturally and linguistically appropriate HIV-related services. The thrust of this initiative was the desire to assist New Jersey organizations that provide HIV services to adopt policies and operating procedures that incorporate federal CLAS standards.

The DOAPC, in collaboration with the AIDS Education and Training Center (NJAETC) at the University of Medicine and Dentistry of New Jersey (UMDNJ), designed a series of workshops throughout the state to promote the need for responsive and effective culturally appropriate services. As an outgrowth of the workshops, a statewide Select Member Cultural Competency Task Force (SMCC Task Force) was established to adapt the federal CLAS standards to address the specific cultural competency challenges of New Jersey HIV service providers.

The SMCC Task Force drew on two primary resources for their deliberations: the 2001 federal CLAS standards described above, and the *Organizational Cultural Responsiveness* model for implementing cultural competency standards. This model, formulated by Parvin Ahmad-Khanlou, PhD, CHES, of the NJDHSS, DOAPC, was designed to assure that recommendations for the New Jersey Cultural and Linguistically Appropriate Service Standards (NJCLAS standards) would be practical and applicable in current New Jersey HIV service settings. The elements of the model are incorporated into every one of the NJCLAS standards. (A list of the members of the Task Force and a diagram of the model can be found in Appendix I and II, respectively).

NEW JERSEY CULTURALLY AND LINGUISTICALLY APPROPRIATE STANDARDS

Guiding Assumptions

The following principles guided the Task Force in the development of the NJCLAS standards:

- NJ CLAS Standards are proposed as a means of correcting current inequities and increasing the responsiveness of services to all clients of HIV/AIDS prevention and treatment organizations.

- The NJCLAS standards are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services, particularly: women, people of color, Latino populations, injecting drug users, men who have sex with men, transgendered individuals, individuals who exchange sex for resources, and people with HIV and AIDS.

Guiding Assumptions (cont.)

- Cultural competency should be the initial focus, or "lens" through which policy, planning, training, service delivery, and program evaluation should be developed, rather than a "filter" applied at the end of the process.
- A commitment to being culturally competent and linguistically appropriate should permeate every aspect of an HIV agency's services on every level, and this commitment should reflect the agency's interactive partnership with the populations served**.**
- The NJCLAS standards are primarily directed at HIV/AIDS service provider organizations; however, agencies are also encouraged to use them to make their services and practices more culturally and linguistically accessible.
- Agencies that are committed to implementing the NJCLAS standards must demonstrate the ability to target attention and resources to the needs of culturally diverse populations**.** Strategic planning will be necessary to:
    - Define and structure activities,
    - Develop policy;
    - Set appropriate goals;
    - Identify, monitor and evaluate system features that warrant new policies or programs to promote consistency with the overall mission.

- Agency incorporation of NJCLAS standards can lead to more efficient use of healthcare dollars and contribute to increased productivity and reduction of absenteeism and disability. In addition, adoption of the standards can increase client/consumer compliance and satisfaction, which will improve health outcomes. The absence of such sensitivity can result in unnecessary repeat appointments, time rectifying misdiagnoses, unnecessary emergency room visits, longer hospital stays and canceled diagnostic and surgical procedures.

Scope and Intended Audience

All New Jersey providers of HIV related services should adopt these standards. However, all agencies and institutions that receive funds to provide HIV services from the NJDHSS/DOAPC will be required to implement these NJCLAS standards as a condition of their health service grant funded objectives. These standards should be integrated into the delivery of *all* HIV services, including:

- Prevention, including: outreach, drop-in center, health education/risk reduction, case management, risk reduction counseling, counseling and testing, and partner notification;
- Treatment, including: assessment, case management, medical treatment, drug treatment; health care and home health care; and
- Human and social services, including: housing and food, transportation, substance abuse treatment, mental health, crisis intervention, and buddy services.

Additionally, NJCLAS standards can make a significant contribution to the following stakeholders:

- *Policy makers*
  NJCLAS standards provide assistance for drafting consistent and comprehensive laws, regulations, and contract language. This has relevance for federal, state and local legislators, administrative and oversight staff, and program managers.

- *Accreditation and credentialing agencies*
  NJCLAS standards provide guidance for assessing and evaluating the delivery of care by HIV service providers to diverse populations. The standards can assist, for example, the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, the Commission on Accreditation of Rehabilitation Facilities, professional organizations such as the American Medical Association and American Nurses Association, and quality review organizations such as peer review organizations.

- *Consumers*
  NJCLAS standards can provide criteria for measuring the quality of services, as they reflect the needs of the consumers of HIV-related health care, educational, and treatment services. This audience includes government and employer purchasers of health benefits, including unions.

- *Clients/Patients*
  NJCLAS standards can help clients and patients understand their right to receive accessible and appropriate HIV/AIDS services and to evaluate the cultural competence of the services provided. The standards also serve to heighten community awareness about the need to monitor the accessibility and quality of HIV-related services provided to diverse populations

- *Advocates*
  NJCLAS standards provide benchmark guideposts for evaluation and can promote advocacy for quality health care and HIV service delivery for diverse populations. These standards have relevance for legal and consumer advocates, consumer education/protection agencies, local and national ethnic, immigrant, and other community-focused organizations, and nonprofit organizations that address health care issues.

- *Educators*
  NJCLAS standards embody principles that should be part of any curriculum that is dedicated to raising awareness and measuring the impact of cultural and linguistic competence on HIV/AIDS service delivery. This audience includes educators from health care, social service, and other professional training institutions.

Integration and Implementation

The NJCLAS standards described in this report are the outcome of several years of discussion. They are intended to assure the elimination of disparities in HIV services through the application of practical, responsive principles. Adapting and implementing these standards requires a universally accepted vocabulary. For this reason, an essential glossary of terms related to cultural competence can be found on page 31.

A number of implementation strategies are suggested for each standard. Agencies and individuals are encouraged to review these strategies and to identify additional creative and innovative means of integrating the NJCLAS standards into their programs. *These standards are intended not only for agencies providing direct care, but for all the stakeholders related to the provision of HIV services, including, board members, subcontractors, volunteers, affiliated agencies, community advocates, and most importantly, patients and clients.*

Relevance of Federal CLAS Standards

The New Jersey Task Force reviewed and considered each national standard as outlined in the report of the Office of Minority Health of the US Department of Health and Human Services "National Standards of Culturally and Linguistically Appropriate Services in Health Care" (CLAS). Following each NJCLA Standard, the relevant national standard from which it was drawn is identified.

Acknowledgements

The NJCLAS Standards are the result of the considerable time and effort on the part of many dedicated and committed individuals and organizations in New Jersey. Appreciation is especially due to: Dr. Gloria Rodriguez, former Assistant Commissioner, New Jersey Department of Health and Senior Services, Division of AIDS Prevention and Control, for her leadership in initiating the DOAPC's cultural competency initiative; Dr. Parvin Ahmad-Khanlou, NJDHSS, DOAPC, for her assistance in managing the DOAPC's cultural competency initiative; NJCLAS Select Member Committee members who providing advisory assistance in adapting the federal CLAS Standards; and Mr. Thomas Sauerman and the staff of the AIDS Coalition of Southern New Jersey who conducted a demonstration project related to the implementation of NJCLAS standards.

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NEW JERSEY
CULTURALLY AND LINGUISTICALLY APPROPRIATE STANDARDS

STANDARD 1

HIV/AIDS service providers should ensure that the services that consumers receive from all staff are client centered, understandable, respectful, outcome oriented and compatible with clients' cultural beliefs, practices and preferred language

Standard I states the fundamental basis from which all of the following standards are drawn. Respectful HIV services are responsive to the expressed and unexpressed health-related needs, values, and preferences of clients impacted by the HIV epidemic, particularly, women, people of color, Latino populations, injecting drug users, men who have sex with men, transgendered individuals, individuals who exchange sex for resources, and people with HIV or AIDS. Understandable care involves communicating in the client's preferred language and ensuring that the printed materials are understood. Successful, effective care results in positive outcomes including client satisfaction, appropriate prevention, diagnosis, treatment, maintenance and/or improvement of health status.

Implementation Strategies:

- Develop a code of cultural ethics for all agency staff and volunteers.

- Establish performance standards for client-related respectful care and service delivery. Ensure that every phase of service delivery communicates the agency's commitment to thorough, respectful, conscientious, and indiscriminate service to all clients.

- Develop a plan for ensuring that agency policies and procedures are responsive to the cultural competency needs of the populations impacted by the HIV epidemic. Services should be responsive to the expressed needs of the client, based on a thorough needs- assessment and a mutually accepted client-centered plan for service delivery.

- Conduct an organizational assessment to determine a baseline level of cultural competence in relation of the populations impacted by the HIV epidemic. Follow-up with quarterly assessments for quality assurance.

- Provide client greeting and orientation procedures that are welcoming, informative, and responsive to clients' expressed needs. Provide client orientation and written educational and service materials in the clients' preferred language.

- Develop clear guidelines and protocols for first contact personnel (guards, hotline operators, receptionists) to assure priority of respectful care.

- Design and post a client – agency contract or agreement that outlines both client and agency expectations and responsibilities**.**

- Provide orientation and continuing in-service education for staff and volunteer personnel that focuses on cross-cultural education and training and skills enhancement required to provide culturally competent service to populations impacted by the HIV epidemic.

- Provide clients with information about alternative treatment systems and beliefs and integrate these approaches into treatment plans, as appropriate.

- Provide clients with information about other services available through the primary agency and in the larger community, referring clients to other resources as needed and appropriate.

- Develop a directory of services available both within the agency and in the larger community.

- Measure client/consumer satisfaction by means of client satisfaction surveys, anonymous client suggestions, and client retention monitoring. Encourage clients to provide quality assurance input directly to agency leadership.

- Utilize focus groups to assess client expectations regarding the scope and quality of services provided, as well as feedback on services rendered.

- Ensure that the process by which services are delivered to clients is effective and efficient, providing the facilitation and follow-up required to assure thorough and responsive service delivery.

- Designate a patient advocate, ombudsperson, or case manager with special expertise in cross-cultural communication and interaction as a contact person for clients.

Relevant National CLAS Standard: *Federal Standard 1*: Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Notes:

STANDARD 2

HIV/AIDS service providers should implement strategies to recruit, retain, and promote diverse staff and leadership at all levels of the organization that are representative of the demographic characteristics of the service area.

Staff diversity plays an important role in providing quality care that is responsive to the many cultural and linguistic backgrounds of populations impacted by HIV. Clients may perceive care as more compassionate when they feel staff members share or appreciate their cultural diversity and are capable of providing unbiased service. Staff diversity also contributes to the development of agency policies and operating procedures that are equitable and responsive to diverse client populations. While staff diversity does not in itself ensure culturally competent and sensitive care, it provides a critical component to the delivery of responsive and effective services to all clients/consumers.

Acknowledging the practical difficulties in achieving full racial, ethnic and cultural parity within the workforce, this standard emphasizes a commitment and good faith effort rather than specific outcomes.

Implementation Strategies:

- Incorporate the goal of staff diversity into the organizations' mission statement, strategic plans and objectives. Develop policies and procedures that promote staff retention through diversity and cultural competence.

- Collect staff demographics as a part of the initial self-assessment and compare them to those of the agency's clients, making every effort to ensure that they are consistent.

- To the extent possible, make staff assignments with consideration to those who are representative of the population being served and to whom clients will relate and find accessible and welcoming**.**

- Conduct periodic cultural competency testing or review of all staff.

- Highlight the agency's commitment to cultural competence in newsletters and employment notices.

- Attempt to recruit qualified representatives of the populations impacted by the HIV epidemic, with consideration toward hiring previous clients as staff, wherever appropriate.

- Advertise job openings in culturally relevant publications and websites, providing job descriptions in appropriate languages.

- Establish internships, residencies, and fellowships that may attract culturally diverse staff and volunteers**.**

- In posting available positions, utilize the following national and local resources for posting agency employment opportunities: minority professional and service organizations; minority health organizations; newsletters of ethnic and HIV service associations and organizations; substance abuse treatment bulletins, newsletters, and professional organizations; and gay, lesbian, bisexual, and transgender associations and agencies.

- Utilize personal contacts to identify individuals who would be culturally and linguistically appropriate to fill vacant staff positions. Sponsor agency "Open-house" events to attract prospective candidates from the community.

- Utilize employment agencies that are experienced in diversity hiring practices.

- Provide educational opportunities, mentoring, and partnerships, especially those related to cultural competency capacity building, as incentives for employment and promotion.

- Assist individuals from various cultures to complete required training needed to qualify for varied job positions. Provide structured training, internships and apprenticeships to community members with little or no knowledge of healthcare.

- Review staff performance evaluations for measures of cultural competence.

- Monitor staff interactions to avert burn out, conflict, inappropriate demands and expectations, poor performance and inadequate training.

- Create a safe and welcoming environment for staff that demonstrates and appreciation of cultural differences, to encourage staff longevity and reduce turnover.

- Adopt specific policies focused on staff satisfaction to reduce staff turn-over:
  - Develop appropriate organizational and supervisory policies and procedures, including appropriate culturally sensitive promotion policies;
  - Establish equitable due process policies and procedures;
  - Conduct regular staff meetings that provide opportunities for open dialogue and participatory planning and evaluation;
  - Promote ongoing dialogue between staff and supervisors to assist staff in evaluating the agency's competency;
  - Ensure that agency staff wages are comparable to salary and wage benefits offered at equivalent agencies and positions in the larger community; and
  - Provide staff access to confidential mental health services to address, among other issues, stress and burn out.

Relevant National CLAS Standard: ***Federal Standard 2*****:** Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Notes:

STANDARD 3

HIV/AIDS service providers should ensure that staff at all levels and across all disciplines receives ongoing education and training in culturally and linguistically appropriate service delivery.

Recruiting and retaining a diverse staff is only the first step toward ensuring proper attitudes and the provision of culturally competent care. Agency staff and volunteers interact with clients and consumers on a daily basis; consequently, it is important that ongoing cultural competency assessment and training be integrated into the daily activities of the agency. These principles and standards should be adopted not only by the agency itself, but also by subcontractors and outsourced services.

It is important that agency cultural competency training be based on sound educational principles and be facilitated by qualified individuals. Curriculum should include pre-and post training assessment and focus on the specific demographics of the target client populations. Cultural competency education can be provided directly by the agency, or by qualified consultants or other qualified associations available in the community.

Implementation Strategies:

- Design and adapt cultural competency training for all staff, including administrative and professional staff (directors, supervisors, board members, and support staff); clinical staff (physicians, nurses, clinician, social workers, case managers, counselors, nutritionists and others); non-clinical staff (outreach workers, health educators); and volunteers. Incorporate requirement of ongoing cultural competency training into agency policies.

- Develop an assessment mechanism to measure staff cultural competency skills and to identify training needs. Assessment can take place in the context of routine supervisory quality assurance performance evaluation reviews or during staff cultural competency educational training.

- Involve community and consumer representatives in the development and delivery of the cultural competency education and training programs.

- Provide easy access to cultural competency education programs and monitor staff participation.
  - Design training programs to be discipline-specific, but also promote cross training among disciplines.
  - Identify organizations and institutions in the community that provide outstanding and highly regarded educational opportunities.
  - Require documentation of successful completion of training programs.
  - Assign managers the task of individualizing training programs to meet the specific needs of the staff member.
  - Review and revise training programs to meet quality assurance, continued relevance, and efficacy standards.

  - Partner with other small agencies to maximize opportunities and minimize costs.

- Integrate ongoing cultural competency education into agency policies, using regular staff meetings and events.

Relevant National CLAS Standard: *Federal Standard 3*: Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Notes:

STANDARD 4

HIV/AIDS service providers should render all services in the preferred language of their clients at every point of service delivery, utilizing the services of bilingual staff and interpreters at no cost to the client.

This standard is based on Title VI of the Civil Rights Act of 1964 with respect to individuals with limited English proficiency (LEP). The Civil Rights Act is provided in Appendix VI. The goal is to provide meaningful access and effective communications between individuals and the service organization or agency. HIV-related services must be made available in the client's preferred language.

Implementation Strategies:

- Establish an agency language advisory board to assess the agency's language and interpreter needs, and to recommend agency language interpretation and translation policies.
- Annually assess the language demographics of client populations to determine agency interpreter and translation needs.
- Enlist the assistance of other community members, academic linguists, language schools, and other English-as-second-language resources.
- Recruit the assistance of bilingual staff and volunteers to provide translation or interpreter services. Review staff schedules to assess the availability of bilingual staff that can communicate directly with patients/consumers in their preferred language during agency hours of operation.
- Initiate partnerships with organizations and agencies that have the capacity to provide language translation services.
- Create a directory of available language interpreter and translation services.
- Establish policies and procedures for utilizing onsite and telephone interpreter and communication services, including telephone resources for the hearing and visually impaired.
- Publicize language interpretation and translation policies to staff and consumers, explicitly describing the right of each client to free language assistance.
- Provide appropriate interpretation services for hearing impaired clients.
- Provide Braille interpretation services for visually impaired clients and utilize pictorial signs and visual aids for low literacy clients.

- Evaluate the quality of language interpretation services through client quality assurance and satisfaction reviews, establishing language accessibility as one of the agency's quality assurance indicators.

- Define a minimum standard of language proficiency and basic interpreter skills necessary to promote quality care. Ensure that language interpreters and translators are capable of translating medical and technical terms that are used in providing client services.

- Include language interpretation and translation as part of the staff cultural competency training, emphasizing their role in the facilitation of providing services in the clients' preferred language.

- Identify and seek federal and state funding to assist in provision of oral and written interpreter and translation service.

- Advocate for reimbursement of translation service with insurers and managed care organizations.

Relevant National CLAS Standards*:*

Federal Standard 4**:** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each client/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
Federal Standard 5: Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
Federal Standard 6**:** Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the client/consumer).

Notes:

STANDARD 5

HIV /AIDS service providers should make available easily understood written materials and signage in the clients' preferred language.

Services provided in the client's preferred language, both verbal and written, will improve quality outcomes and the overall quality of care. All consumers with limited English proficiency should be informed that they have the right to free language services that are readily available. Printed materials and other resources should be responsive to the clients' cultural framework and life experience.

Implementation Strategies:

- Assure that all materials printed in English and distributed by the agency in the context of HIV service delivery have parallel editions in the language of the clients served.

- Purchase computer software (CD ROMs) that can produce materials in the language of the consumers' choice and provide staff with training to assist in the utilization of these resources.

- Distribute easily understood informational pamphlets and resources that address the HIV prevention and treatment needs of the New Jersey populations that are significantly impacted by the HIV epidemic.

- Collect data to assess the impact of the availability of printed materials in the clients' own language on client satisfaction and retention.

- Foster a relationship with the local Office of Civil Rights to ensure implementation and receive ongoing technical assistance in achieving the goals.

Relevant National Standard: ***Federal Standard 7****:* Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Notes:

STANDARD 6

HIV/AIDS service providers should ensure that socio-demographic and culturally related data are collected, tracked, and used in strategic planning and program implementation. Data should include: race, ethnicity, spoken and written language, sexual orientation, gender identity, and substance abuse history

The collection of appropriate socio-demographic data is essential to identifying the populations requiring services within an agency's geographic service area. An accurate demographic profile of the populations impacted by the HIV epidemic in the area is critical to planning. Data collection is necessary for assessing the needs of populations targeted for services, monitoring utilization of agency services and allocating resources.

Individuals should be allowed to designate their own racial, ethnic and cultural identity, consistent with the Office of Management and Budget's policy adapted in the US Census 2000. Data collection should be initiated at the first contact with the agency. Agency staff should apprise all clients of the confidential nature of all data that the client shares.

Implementation Strategies:

- Establish an agency data management committee to oversee policies and procedures related to the collection, processing, interpretation, and usage of data related to client service delivery.

- Establish policies to integrate data collection for each service and program including the initial interview and all subsequent interactions. Policies should integrate the following principles:

  - All staff that provide HIV-related client services should document adherence to the policies at every stage of the client's relationship with the agency, and the documentation should become part of the client's confidential file;
  - National, ethnic, racial, and subgroup identification data should be collected to ensure that culturally competent services are provided to the client;
  - All client data should be treated as confidential, subject to the laws and regulations governing confidential records;
  - Anecdotal information or data related to a client, or data gathered through cursory observation should not be documented, unless confirmed by the client;
  - Clients should not be denied services for failure to provide personal information;
  - Intake/registration staff should be educated about effective, culturally competent methods of data collection;
  - Clients' preferred language should be documented in client file or management information system record in order to ensure that language interpreter services may be available to the client, as needed;
  - Clients should be informed of the availability of interpreter services in the event that they are unable to communicate in English; and

  - Clients should be advised that the purpose of data collection is to facilitate delivery of responsive and culturally competent care, and not to discriminate or deny care.

- Develop comprehensive forms that are inclusive of racial, linguistic and ethnic categories.

Relevant National Standard: ***Federal Standard 10****:* Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Notes:

STANDARD 7

HIV/AIDS service providers should conduct an initial and ongoing organizational self-assessment of culturally competent and linguistically appropriate related activities.

HIV service providers are expected to integrate cultural competency principles into agency or institutional activities and services, at every level. Agencies funded by the NJDHSS/DOAPC must implement NJCLAS standards as a condition of their funded objectives. An initial agency or institutional cultural competency self-assessment can provide a baseline to define agency cultural competency service needs, identify areas that may require improvement, and is useful in developing action plans for enhancing cultural competency. The initial cultural competency needs-assessment should focus on agency capacities, strengths, and weaknesses in relation to the NJCLAS standards.

Implementation Strategies:

- Establish an agency cultural competency task force consisting of representatives from all agency sectors (administration, board members of directors, staff, volunteers, and clients) delegated to:
  - Adopt cultural competency standards for the agency based on NJCLAS standards;
  - Conduct the agency's initial cultural competency needs assessment; and
  - Develop the agency's initial cultural competency plan.

- Encourage each service unit within the agency to enter into a dialogue with the goal of assessing the cultural competency of the services and recommendations for improvement.

- Measure each agency's capacity to be responsive to and to provide unbiased, professional service to the populations severely impacted by the HIV epidemic. Conduct cultural competency assessments annually, developing subsequent cultural competency enhancement plans, as needed.

- Recruit assistance and input from clients and former clients in conducting the agency cultural competency needs-assessment**.**

- Present the agency's initial cultural competency plan to agency administrators, board members, staff, volunteers, and clients as part of an effort to obtain broad support for agency effort to enhance cultural competence.

- Include adherence to NJCLAS standards in staff Performance Evaluation and Improvement reviews.
  - Develop cultural competency indicators for staff evaluation and improvement reviews; and
  - Develop a tool for measuring the cultural competency of staff practices and behavior.

- Provide cultural competency training for all staff, as required by the agency's initial cultural competency needs assessment, particularly to assist staff in developing the knowledge base and skills needed to provide quality, professional, unbiased service to the populations impacted by the HIV epidemic.

- Develop and implement client satisfaction measurement tools.

- Utilize or establish linguistic competence levels using Office of Minority Health/ Office of Civil Rights standard.

Relevant Federal Standard: *Federal Standard 9*: Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Notes:

STANDARD 8

HIV/AIDS service providers should maintain the most current demographic and epidemiological profile and needs-assessment to plan for and provide services that respond to the cultural and linguistic characteristics of their clients.

A comprehensive socio-demographic and epidemiological profile of an agency's catchment area enables the agency to understand the populations targeted for services, and plan services with a sensitivity to potential clients' cultural and linguistic characteristics. The epidemiological profile must be particularly aware of the specific populations impacted by HIV within its catchment area.

It is important to note that a full epidemiological profile frequently requires more extensive data than is available in an agency's database. To obtain a comprehensive profile of the populations to be served, an agency may need to utilize a variety of resources including: census and voter registration data, school enrollment profiles, county, State, and national health reports, and information obtained from other agencies serving the same targeted populations.

Implementation Strategies:

- Initiate a strategic planning process to develop and implement new policies, or modify existing practices to ensure that agency plans incorporate NJCLAS standards and are responsive to the cultural competency needs of the targeted populations.

- Integrate the socio-demographic and epidemiological profile of populations in the catchment area into the planning process. Utilize current agency needs assessments compiled for grant applications as a starting point for developing client population profiles.

- Identify staff members or departments within the organization that will be responsible for obtaining and maintaining relevant socio-demographic and epidemiological data related to the populations targeted to receive HIV services, utilizing agency databases, and local, county, State, and federal health reports and profiles.

- Assign specific staff members or departments the task of creating data collection and analysis tools to maintain and facilitate use of client and community data. This function should report to the highest level of the organization.

- Involve client focus groups and surveys to develop profiles of targeted service populations.

- Establish a board committee with accountability for implementing the strategic plan for cultural competence. Encourage members of the community to participate in the design and monitoring of the process.

- Monitor the responsiveness of the organization to the cultural and linguistic needs of clients/consumers with an ongoing, well-defined process.

- Communicate the agency's successes in providing culturally competent services to populations targeted to receive services

Relevant Federal Standard: *Federal Standard 11*: Health care organizations should maintain a current demographic cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Notes:

STANDARD 9

HIV/AIDS service providers should develop and implement a written strategic plan that outlines clear goals, policies, operational plans, management and accountability mechanisms to provide culturally and linguistically appropriate services.

Strategic planning for cultural competence requires the integration of sensitivity to the clients' values, language, life experience, and needs into the mission, policies, procedures, and activities of the agency. This process requires an intensive focus and an ability to draw on a variety of resources to assure an effective and successful outcome. The agency's commitment to its mission is measured by its success in providing services that are responsive to the real needs of the clients its serves. Carefully considered strategic plans, operational policies, procedures, and management and accountability standards will ensure culturally competent and responsive services incorporating the values, beliefs, sensitivities and life experiences of the New Jersey populations impacted by the HIV epidemic.

To fulfill the goals and objectives of its strategic plan for providing HIV services, an agency needs the commitment and participation of everyone connected to the agency's operations—administrative staff, board members of directors, staff, and volunteers. Additionally, the active participation of stakeholders in the community, consumers and clients is essential to guaranteeing culturally competent, quality service. Effective strategic planning is an ongoing process of analysis and refinement of policies, procedures, monitoring and evaluation mechanisms

Implementation Strategies:

- Recruit staff and board leadership who demonstrate a strong commitment to making available culturally competent HIV services to persons impacted by the HIV epidemic.

- With the participation of the staff, board members, clients and consumers, develop a written strategic plan to encompass all of the NJCLAS standards. Identify culturally competent resources to assist in the strategic planning process.

- Utilize client focus groups to provide input in developing culturally competent strategic plans**.**

- Analyze relevant socio-demographics and epidemiological profile data in the development of culturally competent and linguistically appropriate strategic service plans.

- Conduct ongoing audits to identify challenges that agency staff face in providing culturally competent and linguistically appropriate service to HIV-related target populations, and develop relevant supervisory and educational strategies to address these challenges.

- Schedule regular strategic planning meetings to develop strategies for addressing the cultural competency challenges confronting agency staff.

- Provide ongoing cultural competency education and training to agency staff that focuses on the values, beliefs, language, and life experience of the New Jersey populations impacted by the HIV epidemic.

- Incorporate culturally relevant questions in patient satisfaction surveys and other evaluation instruments to measure client perceptions of the cultural competency of agency services.

- Provide the board of directors with periodic progress reports regarding agency successes and challenges in integrating NJCLAS standards into agency services that are funded by the NJDHSS/DOAPC.

- Include a statement regarding the agency's commitment to implement NJCLAS standards in funding proposals targeting state, federal, and private funding sources.

- Encourage those responsible for writing agency grant proposals to include measurable goals and objectives, strategies and expected outcomes that are culturally competent.

- Promote the inclusion of cultural competence training and planning as part of the technical assistance to be provided in all of the State contracts and assignments.

Relevant Federal Standard: *Federal Standard 8*: Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Notes:

STANDARD 10

HIV/AIDS service providers should ensure that conflict and grievance/complaint processes are culturally and linguistically sensitive and capable of identifying, preventing and addressing cultural differences that might result in conflicts.

It is important that HIV service providers be responsive to the inevitable cross-cultural differences that may arise in the delivery of services. Clients frequently present a variety of issues, behaviors, beliefs, and conditions that have the potential of placing them in conflict with service providers and others who do not share their demographic identities. This may be especially true of populations impacted by HIV, who are frequently confronted with providers and others who are intolerant and disapproving. Individuals with low literacy skills face additional challenges when confronted with the complex delivery of healthcare and medical treatment services that may include technical terms, anticipation of long-term needs, and informed consent.

Lack of complaints from these consumers should not be construed as evidence that conflict or discrimination is absent. Individuals may not recognize that they are being treated inappropriately, or they may fear that a complaint will be either disregarded or provoke retaliation and denial of services. Often clients feel that do not have the right to voice their concerns and complaints**.**

Implementation Strategies:

- Express the commitment of agency administrators and board members to cultural diversity, cultural competence and linguistically appropriate service standards. Communicate support for monitoring and grievance processes that promote effective, quality services and responsiveness to the populations served by the agency.

- Provide clients with information about the agency's grievance and complaint policies and procedures at intake, in a language and format that can be easily understood, especially for those for whom English is not a first language. Develop forms for obtaining client input in the languages of the clients served.

- Provide notice of the individual's right to file complaints or grievances in the preferred languages of agency populations.

- Train individuals who process complaints and grievances to be mindful of cultural competency or linguistically appropriate issues.

- Incorporate monitoring of the grievance/complaint process in the overall quality assurance programming. Conduct cultural audits to identify any problems and assure that NJCLAS standards are being incorporated into the grievance and complaint process.

- Include questions related to understanding of the grievance/complaint process in patient satisfaction surveys and other evaluation instruments.

Relevant Federal Standard: *Federal Standard 13*: Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Notes:

STANDARD 11

HIV/AIDS service providers should collaborate with the communities they serve and utilize a variety of mechanisms to facilitate involvement in the design and implementation of culturally competent and linguistically appropriate activities.

Collaboration is the key to ensuring that comprehensive, culturally competent and responsive services are provided in an atmosphere that promotes client/consumer satisfaction. Client-centered services that are developed in collaboration with the populations served are more likely to be received favorably by prospective clients, and are more likely to promote individual compliance with agency recommendations and treatment plans.

Partnerships with other service providers in the broader community maximize resources and expand the individual agency capabilities, while reducing redundancy and fragmentation of services. Community partners are essential to the tasks of intensifying outreach, building provider networks, promoting appropriate referrals, and advancing awareness of available services. Each agency brings a unique understanding of special populations or community groups that enhances the abilities of all organizations.

Implementation Strategies:

- Develop and maintain formal and informal mechanisms fostering collaboration with the community and other service providers regarding the development of agency strategic plans that are culturally competent and linguistically appropriate.

- Reach out to community gatekeepers, advocacy groups, and other community organizations and associations through focus groups, town meetings, surveys, and other outreach strategies. Make a conscientious effort to specifically elicit the participation of populations impacted by the HIV epidemic. Use these relationships to access community input in developing culturally competent community profiles, strategic service plans, and evaluations of agency services.

- Actively solicit input from other agencies regarding organizational policies, cultural competency standards, evaluation mechanisms, staff training, and other essential programs and services.

- Partner with other agencies, such as churches, government entities, or organizations in designing and implementing activities to assist in the development and implementation of cultural competency standards.

- Provide collaborating partners with periodic reports on the benefits and outcomes of their participation.

Relevant Federal Standard: *Federal Standard 12*: Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and client/consumer involvement in designing and implementing CLAS-related activities.

Notes:

STANDARD 12

HIV/AIDS service providers should regularly disseminate to the public information about the organization's progress in implementing cultural competency and linguistically appropriate standards.

Sharing information with the community about an organization's commitment to cultural competency and linguistic appropriateness accomplishes many goals. It demonstrates the agency's commitment to serving the needs of the community and can serve to institutionalize policies, procedures, and strategies that embody the agency's commitment. Highlighting the cooperation can focus both the agency and the larger community on mutually accepted goals and promote dialogue both within an agency and between the agency and the community.

Implementation Strategies:

- Create and disseminate quarterly or annual reports that provide consumers, staff, and the community with an update on agency progress in implementing cultural competency and linguistically appropriate standards.

- Introduce information about cultural competency activities, plans, and collaboration with the community in other publications of the agency.

- Utilize a variety of media to share information with the larger community, including: special reports; newsletters; news releases; television, radio and cable announcements; presentations at community groups, professionals organizations, information on available Web sites; and community gatherings**.**

- Maintain a database of essential information that staff or board members can incorporate into presentations to the community and funding proposals.

- Initiate innovative means of reaching new communities including creation of list-serves, and outreach to community settings that provide access to perspective clients and community stakeholders (malls, shopping centers, barber and beauty shops, markets, etc.)

Relevant Federal Standard: *Federal Standard 14*: Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Notes:

APPENDICES

I. GLOSSARY

II. SELECT MEMBER TASK FORCE FOR CULTURAL COMPETENCY STANDARDS ((SMTFCCS)

III. ORGANIZATIONAL CULTURAL RESPONSIVENESS MODEL

IV. INTERNET RESOURCES

V. ORGANIZATIONAL RESOURCES

VI. PUBLICATIONS

VII. TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

APPENDIX I
Glossary

***All points of contact*:** Any means of initiating and maintaining meaningful interaction between a client or consumer and the service provider organization.

***Client/Consumer*:** Anyone who has the potential to use services, including, patients, trainees, clinicians, and clients.

***Commonly encountered languages*:** Languages that are used by a significant number or percentage of the populations in the service area.

***Cross-Cultural*:** Differences that might exist in the communication styles of clients/ consumers, administrators and staff in culturally diverse communities.

Current: Information that is timely and reviewed at least annually.

Culture: The shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people that are unified by race, ethnicity, language, nationality, or religion.

***Culturally Appropriate*:** Demonstrating sensitivity to cultural differences and similarities as well as effectively using cultural symbols to communicate a message.

***Cultural Competence*:** A set of interpersonal skills that enables individuals to communicate understanding, acceptance, and appreciation of cultural differences and similarities, requiring a willingness and ability to draw on community-based values, traditions, and customs, and to work with knowledgeable persons from the community in developing targeted interventions, communications, and other supports.

Cultural Diversity: Differences in race, ethnicity, language, nationality, or religion among various groups within a community; a community is said to be culturally diverse if its residents include members of different groups.

Demographic: Data about age, race, gender (male, female, transgender, intersexes), income, locality/address, educational level, occupation, language, disability, literacy, and religion.

Diverse staff: Staff profile representative of the diverse demographic population of the service area; both personnel employed by the HIV/AIDS service provider and also its subcontracted and affiliated personnel.

Easily understood: Assuring that materials and communication are clear and meaningful to the listener through a focus on literacy, language and cultural comprehension.

Ethnicity: A common group, often linked by race, nationality, and language with a common cultural heritage and/derivation.

Grievance: A significant disagreement that relates to a decision, policy or action.

Grievance/complaint process: Mechanism initiated to address a concern or disagreement that promotes full participation to identify facts and achieve a fair and equitable resolution.

Individual with limited English proficiency (LEP): An individual who cannot speak, read, or understand the English language at a level that permits him/her to interact effectively with clinical or non-clinical staff. (Patients requiring American Sign Language and literacy would also be covered by this standard).

Initial self-assessment: An initial inventory of organizational policies, practices, and procedures prior to developing cultural competence strategies for provision of HIV/AIDS services; a prerequisite to developing and implementing the strategic plan. Focus is placed on capacities, strengths and weaknesses of the organization in meeting CLAS standards.

Meaningful access: Ensuring effective communication between the service provider organization and the Limited English Proficiency individuals.

Multicultural: Designed for or pertaining to two or more distinctive cultures.

Ongoing: Education and training which is continuous and regularly scheduled, designed to meet specific objectives tailored for relevance to the particular functions of the trainees and the needs of the specific population served. Education programs should be monitored and assessed to determine progress toward and achievement of training goals.

Positive outcomes: Assessment of consumer satisfaction and maintenance or improvement of health status or other specific goals to be determined.

Preferred language: The language in which an individual feels most comfortable in a clinical or non-clinical encounter.

Professional Interpreter: An individual trained and certified in medical interpretation, which requires a set of skills, ethical considerations, and superior technical ability.

Race: A socially defined population that is derived from distinguishable physical characteristics that are genetically transmitted.

Regularly: An event or process that occurs on a specific schedule; annually or quarterly or any period deemed appropriate.

Relevant/essential client/consumer related materials: A set of document, including Consumer Bill of Rights, applications, consent forms and medical/treatment instructions, and other written materials necessary for effective service delivery.

Respectful care: Care that is responsive to the expressed health-related needs, values, and preferences of the patient/consumer.

Services: The activities of the agency directed to the client/consumer including care, prevention and education, training, treatment, and planning.

Staff: Personnel employed by the HIV/AIDS service provider as well as subcontracted and affiliated personnel and members of the board members.

Staff at all levels: Those individuals providing services including: clinical staff (doctors, nurses, healthcare professionals); support staff (receptionists, intake, etc.); administrative staff (secretaries, billing department, etc.); clergy and lay volunteers; high-level decision-makers (senior managers, corporate executives); and governing bodies (board of directors).

***Strategic Planning*:** A process that helps an organization to define and structure activities, policy development, and goal setting relevant to culturally and linguistically appropriate services. An ongoing effort that requires identifying, monitoring and evaluating system features that may warrant new policies or programs consistent with the overall mission.

Timely manner: An immediate response; as soon as the need arises.

Understandable care: Communicating in the preferred language of consumers and ensuring that they comprehend all HIV/AIDS services and administrative information.

Written documents and material: All materials that are essential to the client/consumer to make educated decisions about health including: applications, intake forms, consent forms, medical or treatment instructions and educational documents.

Notes:

APPENDIX II

Select Member Task Force for Cultural Competency Standards

Parvin Ahmad Khanlou
New Jersey Department of Health and Senior Services, Local Health and Emergency Services

Dafne Fumero Armstrong
AIDS Coalition of Southern NJ

Edwin E. Dunga
Urban Community Services

Loretta Dutton
New Jersey Department of Health & Senior Services, Division of AIDS Prevention & Control

Bernice Ferguson
M.L. King Academy

Félix E. Gardón
UMDNJ-CCOE-Division of AIDS Education/NJAETC

Lorna Jones
New Jersey Department of Health & Senior Services, Division of AIDS Prevention & Control

Kimi Nakata
UMDNJ-CCOE-Division of AIDS Education/NJAETC

Dion Richetti
UMDNJ-CCOE-Division of AIDS Education/NJAETC

Samuel Roberson
Essex Substance Abuse Training Center

Sherri Rucker-Graves
Atlantic City Health Department

Thomas Sauerman
AIDS Coalition of Southern NJ

Stephen Saunders
New Jersey Department of Health & Senior Services, Division of AIDS Prevention & Control

Migdalia Thompson
Camden AHEC (Area Health Education Center)

Alfred J. Vasapolli
New Jersey Department of Health & Senior Services, Division of AIDS Prevention & Control

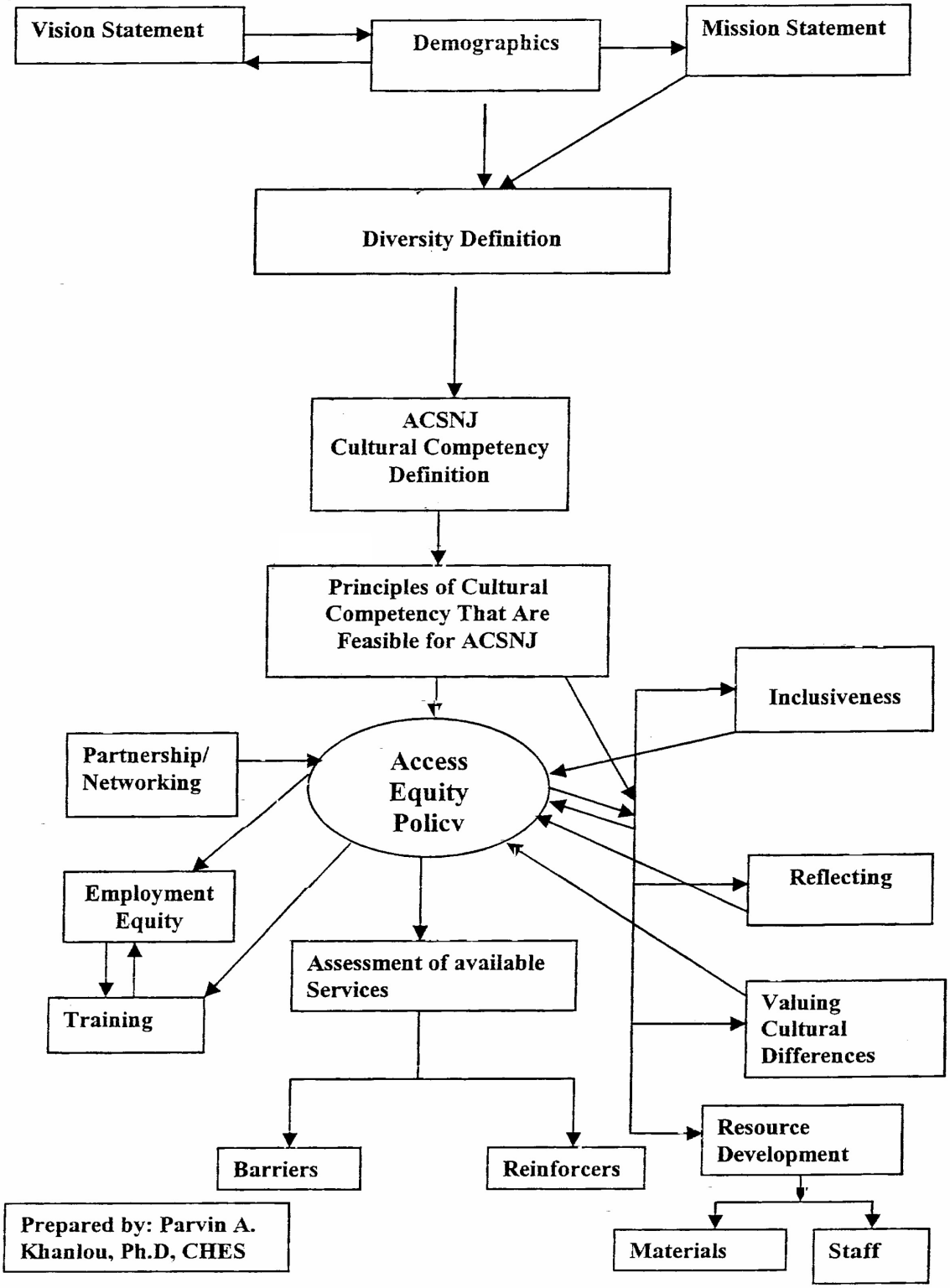
Karen J. Walker
Paterson Counseling Center

Viola Warren
AIDS Coalition of Southern NJ

Caryn Weir-Wiggins
Virginia Commonwealth University

APPENDIX III

ORGANIZATIONAL CULTURAL RESPONSIVENESS MODEL



APPENDIX IV

INTERNET RESOURCES

National MultiCultural Institute	http://www.nmci.org
University of Maryland Diversity Database	http://inform.umd.edu/EdRes/Topic/Diversity
The Multicultural Pavilion At UVA	http://curry.edschool.virginia.edu/go/multicultural
Topics in General CrossCultural Care	http://healthlinks.washington.edu/clinical/ethnomed/htopics.html
Department of health & Human Services, Office of Minority Health	http://www.omhrc.gov/welcome.htm
Healthfinder	http://healthfinder.gov
American Public Health Association	http://apha.org
PsychScapes Worldwide Connections in Mental Health	http://www.mental-health.com
Mental Health Internet Resources	http://www.mirconnect.com
National Coalition of Hispanic Health and Human Services Organizations	http://www.cossmho.org
The International Association For Cross Cultural Psychology	http://www.fit.edu/ft.edu/ft-orgs/iaccp/

APPENDIX V

ORGANIZATIONAL RESOURCES

BUREAU OF PRIMARY HEALTH CARE (BPHC)
Health Resources and Services Administration
(HRSA) 4350 East-West Highway, 3rd Floor
Bethesda, MD 20814
http://www.bphc.hrsa.dhhs.gov

CENTER FOR HEALTH SERVICES FINANCING AND MANAGED CARE
Health Resources and Services Administration
(HRSA) 5500 Fishers Lane, Room 10-29
Rockville, MD 20857
(301) 443-1550
http://www.hrsa.gov/cmc
http://hrsa.gov/medicalprimer

CENTER FOR MULTICULTURAL AND MULTILINGUAL MENTAL HEALTH SERVICES
4750 N. Sheridan Road, Suite 300
Chicago IL 60640
(773)271-1073
http://www.mc-mimhs.org

CROSS CULTURAL HEALTH CARE PROGRAM
270 So. Hanford St., Suite 100
Seattle, WA 98134
(206) 860-0329
http://www.xculture.org/contact/index.html

DIVERSITY RX
http://www.diversityrx.org

ETHNOMED
http://www.hslib.washington.edu/clinical/ethnomed

HRSA INFORMATION CENTER
PO Box 2910
Merrifield, VA 22116
1-888ASK HRSA
http://www.ask.hrsa.gov

INITIATIVE TO ELIMINATE RACIAL AND ETHNIC DISPARITIES IN HEALTH
US Department of Health and Human Services
http://raceandhealth.hhs.gov

ORGANIZATIONAL RESOURCES (CONTINUED)

MEDICARE AND MANAGED CARE
Health Care Financing Administration
US Department of Health and Human Services
Hotline 1-800-638-6833
http://www.hcfa.gov/medicare/mgdcar1.htm

MEDICAID AND MANAGED CARE
Health Care Financing Administration
US Department of Health and Human Services
http://www.hcfa.gov/medicaid/mchmpg.htm

MODELS THAT WORK
Bureau of Primary Health Care
Health Resources and Services Administration
(301) 594-4334
e-mail: models@hrsa.dhhs.gov
http://www.bphc.hrsa.dhhs.gov/mtw/mtw/htm

NATIONAL CENTER FOR CULTURAL COMPETENCE
3307 M Street NW Suite 401
Washington DC 20007-3935
1-800-788-2066
e-mail: cultural@gunetgeorgetown.edu

NATIONAL CLEARINGHOUSE FOR PRIMARY CARE INFORMATION
2070 Chair Bridge Road, Suite 450
Vienna, VA 22182
(703) 821-8955 Ext 248
http://www.bphc.hrsa.dhhs.gov

OFFICE OF MINORITY WOMEN'S HEALTH
CULTURAL COMPETENCE PROGRAM
Bureau of Primary Health Care
Health Resources and Services Administration
4350 East West Highway 3rd Floor
Bethesda, MD 20814
(301) 594-4490
http://www.bphc.hrsa.gov/omwh/omwh20.htm

OFFICE OF MINORITY HEALTH
Health Resources and Services Administration
5600 Fishers Lane
Rockville MD 20857
(301) 443-2964
http://www.hrsa.dhhs.gov/dmh

ORGANIZATIONAL RESOURCES (CONTINUED)

OFFICE OF MINORITY HEALTH
Office of Public Health Service
US Department of Health and Human Services
5515 Security Lane Suite 1000
Rockville MD 20852
301-443-5084

OFFICE OF MINORITY HEALTH RESOURCE CENTER
PO Box 37337
Wasjomgtpm. DC 20013-7337
1-800-444-6472
e-mail: info@omhrc.gov
http://www.omhrc.gov

THE QUALITY CENTER
QUALITY AND CULTURE PROGRAM
Bureau of Primary Health Care
Health Resources and Services Administration
4350 East West Highway 11th Floor
Bethesda, MD 20814
301-594-3808
http://www.bphc.hrsa.gov/quality

Notes:

APPENDIX VI

PUBLICATIONS

CULTURAL COMPETENCE GUIDES

Building Bridges: Tools for Developing an Organization's Cultural Competence. La Frontera, Inc., 1995.
Contact (520) 884-9920.

Building Linguistic and Cultural Competence: A Tool Kit for Managed Care Organizations and Provider Networks that Serve the Foreign-Born. Mid-America Institute on Poverty, Chicago: Heartland Alliance, 1999.
Contact (312) 629-4500.

Communicating Effectively Through an Interpreter. The Cross Cultural Health Care Program, 1998 (video).
Contact (206) 860-0329
http://www.xculture.org/contact/index.html

Cultural Competence: A Journey. Bureau of Primary Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, 1999.
Contact 1-800-400-BPHC or website
http://www.bphc.hrsa.gov/culturalcompetence/Defauithtm

Cultural Competence: Program Self-Assessment, Services to Children and Families. (Amherst: H. Wilder Foundation, St. Paul, MN.)
Contact (651) 642-4000.

Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. New York State Office of Mental Health, 1998.
Contact (301) 443-6212

Cultural Competence Standards in Managed Care Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups, Center for Mental Health Services, SAMHSA, 1998.
Contact (301) 443-6212

Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities. Kaiser Family Foundation. (Publication #1362)
Contact (800) 656-4533,

Establishing Interpreter Services in Health Care Settings. Amherst Educational Publishing,
Contact (800) 865-5549

Guidelines to Help Assess Cultural Competence in Program Design, Application, and Management, Bureau of Primary Health Care, Office of Minority & Women's Health
Website: http://158.72.105.163.cc/guidelines.htm

Medicaid Managed Care and Cultural Diversity in California, The Commonwealth Fund, March 1999.
Contact (888) 777-2744.

Monitoring the Managed Care of Culturally and Linguistically Diverse Populations, Tirado, Miguel D., Ph.D. December 1998. Ordering Information - National Clearinghouse for Primary Care Information, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182
Telephone: 1-800-400-2742 or (703) 902-1248, Fax: (703) 821-2098,
E-mail: primarycare@circsol.com

Optional Purchasing Specifications: Cultural Competence in the Delivery of Services through Medicaid Managed Care. Developed by the Center for Health Services Research and Policy under contract to the U.S. Department of Health and Human Services, Health Resources and Services Administration, 2000. Contact: 1-888-ask-hrsa or visit website: http://www.ask.hrsa.gov

Tools for Monitoring Cultural Competence in Health Care, Tirado, Miguel D., Ph.D. January 1996. Available from Latino Coalition for a Healthy California, 1535 Mission Street, San Francisco, CA 94103,
Contact: (408) 582-3967

What is Cultural Competence? Bureau of Primary Health Care, Office of Minority and Women's Health website, http://158.72.163/cc/7domains.htm

JOURNAL ARTICLES:

Can Cultural Competence Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model, Brach, Cindy and Irene Fraser, Medical Care Research and Review, Vol. 57, Supplemental 1 (2000). 181-217.

Cross-Cultural Medicine Issue, Western Journal of Medicine, Dec. 1983 (vol. 139, no. 6).

Cultural Competence: Essential Measurements of Quality for Managed Care Organizations, Editorial, Annals of lnternal Medicine, 124:10 (1996) 919-20.

Language Barriers to Health Care, Journal of Health Care for the Poor and Underserved. Volume 9, Supplemental, 1998. 800-656-4533, publication #1396.

Promoting Cultural Competence in HIV/AIDS Care, JANAC 7, Supplement 1 (1996) 41.

Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care, Like, Robert C. R. Prasaad Steiner and Arthur Rubel, Family Medicine, Vol 8(4):291-297,1996.

HRSA MANAGED CARE
HIV/AIDS BUREAU

Medicaid Managed Care & HIV/AIDS: A Guide for Community-Based Organizations. Produced by AIDS Action Foundation with support from the U.S. Department of Health and Human Services, Health Resources and Services Administration. 2000 (Copies of this publication may be obtained from the AIDS Action Foundation, 1906 Sunderland Place, N.W., Washington, D.C., 20036, (202) 530-8030).

A Resource Guide for Ryan White CARE Act Grantees and Other HIV/AIDS Providers. U.S Department of Health and Human Services, Health Resources and Services Administration. Summer 1998. (Copies of this publication may be obtained from the HRSA Information Center, P.O. Box 2910, Merrifield, VA 22116, 1-888-ASK HRSA, http://www.ask.hrsa.gov).

HIV Capitation Risk Adjustment - the HRSA Conference Report. (Washington, D.C.: Henry J. Kaiser Family Foundation). August 1997. (Copies of this publication may be obtained from the Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, D.C. 20005, (202) 347-5270.)

Adequacy of Reimbursement for HIV Under Section 1115 Waivers. Richard Conviser, Ph.D., Deanna Kerrigan, M.P.H., and Stephen Thompson, MA (Rockville, Maryland: Bureau of Health Resources Development, Office of Science and Epidemiology). 1997. (Copies of this publication may be obtained by contacting the Office of Science and Epidemiology, HIV/AIDS Bureau, 5600 Fishers Lane, Room 7 A-07, Rockville, Maryland, 20857, (301) 443-6560.)

BUREAU OF PRIMARY HEALTH CARE

These publications can be ordered from the HRSA Information Center, P.O. Box 2910, Merrifield, VA 22116, 1-888-ASK HRSA, http://www.ask.hrsa.gov.)

Medicaid Managed Care Education: A Workbook for Health Centers. Rockville, MD: Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. Fall 1998.

Analysis of Managed Care Enrollment in Community and Migrant Health Centers, 1996. Rockville, MD: Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. 1997.

Executive Summary: Evaluation of the Impact of Medicaid Waivers on Consumers and Services of Federally Qualified Health Centers. Prepared by the Lewin Group, Inc. for the Bureau of Primary Health Care, Health Resources and Services Administration. November 10, 1997

Changes in Information Systems in a Managed Care Environment: Training Curriculum for Health Centers and Health Center Networks. Rockville, MD: Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services and the National Association of Community Health Centers. May 1997.

Preparing for Managed Care: Strategies for Community-Based Organizations Serving People with HIV/AIDS. Videotape. Rockville, MD: Bureau of Primary Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. 1997.

Managed Care Internal Operations Self-Assessment Tool for Federally Qualified Health Centers. Rockville, MD: Bureau of Primary Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. October 1994.

JOURNAL ARTICLES

Promoting Opportunities for Community Based Health Education in Managed Care, Gallivan, Leah P.,Lundberg, Mary E., Fiedelholtz, Jennifer B., Andringa, Kim, Stableford, Sue, and Visser, Laura, Journal of Health Education 1998; 29: S-28-33.

APPENDIX VII

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

TITLE VI OF THE CIVIL RIGHTS ACT: A PRACTICAL GUIDE FOR PUBLIC HEALTH AND HUMAN SERVICES PROVIDERS

About thirty-two million people in the United States, or 13.8 percent of the population, speak a language other than English at home. This population of people with Low English Proficiency (LEP) represents new and distinct challenges to health and human services providers. Language barriers pose challenging communication issues at almost every level of the health care delivery system.

WHAT IS TITLE VI?
Title VI of the Civil Rights Act of 1964 is the Federal law that protects individuals from discrimination on the basis of their race, color, or national origin in all programs that receive Federal Financial Assistance.

WHO DOES TITLE VI BIND?
All entities that receive any Federal funding, either directly or indirectly through a sub-grant or sub-contract, are obligated to comply with Title VI. Because Federal funding in health care is pervasive, nearly every health care provider and all health departments in NC are bound by the requirements of Title VI. Covered entities would include, but are not limited to these facilities that receive federal funding:

- All facilities that accept Medicare or Medicaid.
- Hospitals
- Physician offices
- All County Local Health Departments in North Carolina
- Community and migrant health centers who receive federal grants.
- Social Service Agencies
- Mental Health Services

WHAT ARE MY RESPONSIBILITIES UNDER TITLE VI?
Title VI requires linguistic accessibility to health and human services. The U.S. Office for Civil Rights has interpreted Title VI to require all recipients of federal funds to consider the following:

- Offer translation services at no cost to LEP patients;
- Have written policies for staff awareness of the existence of such policies.
- Ascertain the language needs of prospective recipients at the earliest possible opportunity.
- Have a system for tracking LEP clients and client needs.

- Identify a single individual or department that is charged with ensuring the provision of language access services.
- Publicize the availability of no cost programs and services in non-English community newspapers and on non-English radio and television stations.
- Provide written notices to clients in their primary language informing them of their right to receive interpretive service.
- Ask family and friends of LEP patients to provide interpretive service only after alternative, no-cost methods have been explained (Minors should not be used to interpret).
- Ensure the availability of a sufficient number of qualified interpreters on a 24-hour basis, or whenever the facility is open.
- Ensure that interpreters are qualified and trained with demonstrated proficiency in both English and the other language, as well as knowledge of specialized medical and other technical terms and concepts in both languages.
- Limit the use of telephone interpretation to situations where there is no bilingual staff person or contracted interpreter available.
- Have translated materials available.
- Conduct community outreach to immigrant communities.

HOW CAN I GO ABOUT PROVIDING INTERPRETATION SERVICES?

Some ways that you, as a health care provider, can overcome linguistic barriers include:

- Hire qualified bilingual staff.
- Hire staff interpreters.
- Use volunteer staff interpreters.
- Arrange for the services of volunteer community interpreters.
- Contract with an outside interpreter service.
- Use a telephone interpreter service such as the AT&T Language Line.
- Monitor quality and competence of interpreters.

WHERE CAN I TURN FOR HELP?

National Resources:

Civil Rights Division
U.S. Department of Justice
1-888-TITLE06 (1-888-848-5306)